Chapter 6

Treatment of Intrafamilial Crime Victims

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Introduction

This chapter discusses treatment interventions for child victimization that occurs within the family. Forms of intrafamilial child maltreatment include neglect; physical and sexual abuse; and exposure to intimate partner violence (commonly called domestic violence). In planning, providing and evaluating the treatment of a child victim of intrafamilial abuse, the family culture and dynamics must be considered. Complexity is increased by the need to coordinate the treatment of multiple family members as well as a host of case management issues. Because of this complexity, intrafamilial abuse often requires longer treatment interventions than do other forms of trauma.

When abuse occurs within the family system, the child may have been forced to adapt to living with a parent who vacillated between nurturing and predatory behavior. The child may have reacted to the dread of maltreatment with hypervigilance or numbing. Symptoms of chronic posttraumatic stress disorder can coexist with depressive, behavioral and cognitive symptoms. The treating therapist must provide support to the child (who is often emotionally ambivalent toward the parents), while at the same time participating in decisions about the child's safety and the capacities of other family members to care for the child.

In addition to more general concerns resulting from trauma to children (see the "Treatment" chapter), trauma inflicted by a relative, a family member or person in a position of special trust adds another level to the assessment, planning, and implementation components of the treatment process. Physical and sexual abuse of children is almost always accompanied by emotional trauma and often occurs within the context of child neglect. The relationship between the child victim and the offender is usually complex and impacts children in multiple aspects of their emotional and social lives. While emotional impacts such as guilt, ambivalence, and anger may be subtle, overt impacts can follow obvious losses such as removal from the family home, loss of relationships with family and friends, and the challenge of adjusting to life with relatives, foster parents, or residential placement.

Because intrafamilial abuse occurs within the context of a family, all of the family relationships are affected, first by the abuse itself and then by changes in the family system that occur with intervention. Guilt over failure to protect can occur with the non-offending parent as well as with siblings who did not act to help each other. Attributions of blame, both for the abuse and the changes which follow intervention, can co-exist with feelings of guilt. Shame over public exposure of the family's plight can be another issue and another cause for blame. The extended family system can function as a buffer and source of comfort, or it can divide family members and add to the burden of guilt, blame, loss, and shame with which the members of the nuclear family are struggling.

In most cases all family members (child victims, siblings, and non-offending parents) should have access to their own individual or group therapy. Each has his or her own problems and reactions to the abuse to come to terms with before being ready to participate in dyadic or family therapy in a constructive and meaningful way. However, at some point, mental health interventions on behalf of individual family members must also address their family relationships. Dyadic and family therapy, often concurrent with individual or group therapy, can accelerate progress for many children and families. Timing the advent of dyadic and family therapy and managing the intense feelings that can be generated by that therapy, are the central challenges for the therapist in cases of intrafamilial abuse. If family reunification is going to include the offender, or

even renewed contact with the offender through visitation, reunification therapy becomes even more complicated and requires specialized training.

Neglect

Child neglect is the failure of the parent or caregiver to provide for the basic needs of the child, resulting in harm or threatened harm to the child's health or welfare. Neglect is the most common form of child maltreatment, accounting for more than half of the substantiated child maltreatment cases in the United States each year (Department of Health & Human Services, 1998) and is categorized as severe (which threatens the child's life or well-being) or general (less than minimally acceptable standards of care). The most common maltreatment pattern is neglect by a female parent, with young maternal age and poverty the two strongest demographic predictors for neglect.

Neglect manifests itself in many forms. Included are physical neglect (for example, the child is chronically hungry, dirty, sleep deprived, poorly clothed, or inadequately dressed for the weather conditions), emotional neglect (for example, the child is apathetic, withdrawn and depressed), medical neglect (including neglect of dental or mental health needs), or educational neglect.

Examples of neglect include the following:

- A child is left alone in the home or left unsupervised in a car, on the street, or in a public shopping area.
- A child is repeatedly involved in accidents or endangering situations.
- A child is living in conditions that are unsanitary or lack basic heating or plumbing and may have fire hazards and other unsafe conditions present.
- A child is not provided with sufficient or nutritious food.
- A child is living in a situation where parental mental illness, lack of knowledge or substance abuse interferes with the child's basic needs being met.

Effects of Neglect

Neglect may present differently depending upon the age and developmental stage of the child. The long-term effects of neglect can manifest in different ways at different ages. Distinguishing between disorderly poverty (as described above) and emotional neglect requires reconstructing how the child has been cared for and responded to. The damage to the child can be much worse than a thin, dirty body or the unhappiness of living in squalor. Neglect may result in physical, emotional and intellectual delays or permanent disabilities (Glaser, 2000, Crittendon & Ainsworth, 1989).

Since the brain develops with feverish rapidity in the first months of life, and since that development is experience-contingent, a very young child may experience neglect even while living in a clean, well-appointed place. Brain development, the pattern of self-regulation and modulation, the range of responses, and the scope of expectancies can be affected by a parent's incapacity to respond to the child's cues, anticipate needs, buffer intense emotions, and stimulate the child emotionally, verbally, and physically. Emotional and behavioral manifestations of blighted development, and of the frightening feelings it evokes in very young children, can be powerful and lasting.

Treatment Issues Specific to Neglect

The course of treatment must be fitted to the factors that contributed to the neglect. Treatment of the neglected child incorporates interventions that enhance communication, trust, bonding and attachment between parent and child. Neglected children may need intervention for delays in language, cognitive and social skills, as well as emotional problems such as depression. For older children suffering the long-term consequences of neglect, treatment interventions should address the following issues:

- Detachment from others and impaired trust
- Mood disorders (primarily depression and anxiety)
- Feelings of emptiness and deprivation
- Poorly developed sense of self, feelings of worthlessness
- Social isolation and problems forming relationships

School-age neglected children also need assistance developing supportive relationships with adults and peers outside of the home. These community connections are often the only emotional "life-saver" for a neglected child.

Conditions impeding the parents or caregivers from providing appropriate care for the child must be addressed in the treatment process. These conditions include, but are not limited to the following:

- Lack of education or knowledge about infant care
- History of neglect and deprivation
- Substance abuse (alcohol or drugs)
- Intellectual deficits
- Mental illness (depression, personality disorders, psychosis)
- Domestic violence
- Inadequate resources or failure to access available resources
- Cultural or religious practices (which may result in medical neglect)

Individual therapy alone is usually not successful in eliminating neglect or in ameliorating its effects. Because neglect occurs in the context of a family, family members of the neglected child must also be involved in the child's treatment to improve the parent-child relationship, promote healthy child development, and increase the parents' ability to cope with their own stresses. Therapy must be combined with educational programs on healthy parenting or may include components of positive parenting in the therapy itself. Case management services must be available to assist families meet their needs in obtaining basic food, shelter, clothing and medical care.

Alleviating the financial stress of a neglecting parent may not be enough. The parent may also need a caring relationship in order to develop the emotional capacity to care for a young child. The use of home visitors, mentors, early childhood educators and other support persons, including extended family members, can fill this need in ways that therapy cannot. Caution should be taken so that the clinician does not overestimate the benefits of these interventions and underestimate the severity of the parent or caregivers problems in more severe or multi-problem families. These interventions appear to be more effective with first-time at risk mothers or with situational neglect and are less effective in cases of chronic or severe neglect (Gomby, 2000). They are not likely to be adequate interventions in families with frequent domestic violence (Eckenrode et al., 2000). More than one-fifth of the children abused and neglected nationally in 1998 had already received in-home Family Preservation Services (Department of Health and Human Services, 1998). When adjunctive home-based services are provided in neglect cases, it is essential that they be coordinated with psychotherapy and case management in a comprehensive multidisciplinary team model.

Intimate Partner Violence (Domestic Violence)

Intimate partner violence (IPV) refers to physical force or threats of force against a current or former intimate relationship partner, resulting in fear and emotional or physical injury. In the case of children, domestic violence typically refers to violence between the child's parents, adult caregivers or mother and her partner. These parents or caregivers may or may not live together or be biologically related to the child. While

approximately 91% of domestic violence is male against female, in which the husband, ex-husband or male partner batters the woman, males are also victims of domestic violence. It is also important that the existence of same sex intimate partner violence not be overlooked. Although parents often deny, minimize or underreport the extent to which their children were exposed to violence, the majority of children report awareness of the domestic violence in their families. Children exposed to parental domestic violence are at risk for other types of child maltreatment, including physical and sexual abuse (Chicchetti & Riizley, 1981). Even if children do not see or hear the violence, observing bruises and other injuries on a parent is traumatic for children.

Effects of Intimate Partner Violence

Children raised with intimate partner violence have a higher risk for psychopathology than do children raised in non-violent homes (Bietchman et al., 1992). The impact depends to some degree on characteristics of the exposure, such as frequency, intensity and severity of violence. It also depends on characteristics of the child and family that either support or prevent resiliency, such as temperament, cognitive functioning, and quality of maternal care. The impact of domestic violence must be considered in the context of the existence of other types of intrafamilial maltreatment, such as neglect and abuse. Careful assessment for all types of maltreatment should form the basis for all treatment planning.

It is terrifying to a child when their parent's attack each other, and deeply distressing when they fight, even verbally. The child's adaptation to the dilemma of living with warring adults may be logical and ingenious when understood from the child's point of view, even when it is radical enough to meet the criteria for a psychiatric diagnosis. For example, children may have coped with their parents' anger by becoming sick to unify the parents in caring for them, by misbehaving to unify the parents in disciplinary action, by developing aggression to vent their distress and to feel powerful, or by avoiding, withdrawing and dissociating in order to numb the experience. Children who witness domestic violence often have symptoms and DSM-IV conditions similar to children with other forms of child maltreatment.

Exposure to intimate partner violence creates an environment that is emotionally and physically unstable for children. The atmosphere is often highly unpredictable, and children can develop symptoms such as hypervigilance and anxiety. Social relationships for children may be impaired, as they fear bringing peers into their unstable environment. Additional symptoms include guilt at being unable to protect other family member, anger and rage at the perpetrator and devaluation of the adult victim. Emotional responses to the violence can range from aggression to withdrawal and depression. Finally, it should not be overlooked that in addition to the injuries sustained by the adult victim, children are often caught in the violence. This may occur unintentionally or when the child attempts to intervene in the violent situation. The co-existence of substance abuse must also be considered in evaluating the effects of domestic violence. The presence of substance abuse in the family further contributes to chaos, neglect and a sense of unpredictability. Children may begin to use substances as a vehicle for escaping the pain of living in a domestic violence situation.

Treatment Issues Specific to Intimate Partner Violence (IPV)

Therapists should screen for domestic violence history when assessing and treating children traumatized by any type of crime. Children from violent homes should be assessed for mental health problems that require direct treatment intervention, in addition to system interventions designed to ensure child safety.

In assessing for IPV, do not assume that the IPV occurring in the home is the cause of all of the child's mental health issues. It is important to complete an accurate evaluation of each type of violence to which the child has been exposed. Specifically, the assessment should include questions on the following types of violence: violence between adults in the home, violence in the community, natural disasters and violence in the media. The questions used in the assessment process must be designed to assist the client in identifying all violent episodes experienced. This may require helping the client reframe some of the events not previously considered as traumatic or violent events.

Providers must be prepared to advocate for the safety of the child within the legal and child protective services systems. Advocacy for the child will usually require advocacy for the adult victim. Adjunctive advocacy services are often very valuable to child and adult victims and provide another source of emotional support and sense of protection.

Advocacy functions in an IPV situation should avoid labeling the adult victim as a non-protective or neglectful parent. Although intended to protect the child from further exposure to violence, such labeling can re-victimize the adult victim. The National Council of Juvenile and Family Court Judges (1994), developed a model code on Domestic and Family Violence that states "service must be offered to the victimized parent, and the provision of such services must not be contingent upon a finding that either parent is at fault or has failed to protect the child" (p. 38). Advocacy and treatment planning in IPV situations must include a safety plan for both the adult victim and the children. Adult victims of IPV can be at increased risk by the system responses to the violence (Magen, 1999). These risks include being labeled a neglectful parent and losing custody of the children, and may lead victims to recant statements and to conceal additional violent events. The treatment professional must be sensitive to these issues in developing and implementing treatment plans.

The task force is concerned about the automatic assumption that a mother is neglectful of her children or putting them at unnecessary risk if she does not leave a relationship after the first episode of violence. The IPV research suggests that the point of leaving a violent relationship may be a time of increased risk (Mahoney, 1991). Any treatment plan or court order that requires the victim to take this action may be inadvertently placing other family members at additional risk. From the perspective of the battered partner, any decision regarding leaving the relationship must balance multiple variables of concern and risk.

Treatment planning for all children and adults exposed to domestic violence should include safety planning. Family members will best be able to use the therapy process when safety issues have been addressed. Child safety should be a primary concern in treatment plans regarding parental contacts and reunification efforts. Assessments and treatment plans should include consideration of domestic violence history, especially factors such as severity and pattern of past abuse, stage of separation or divorce, lethality factors such as the presence of weapons, prior police involvement, stalking behavior, threats, or fantasies of suicide or homicide.

Fatal Family Violence

When death results from family violence, children have immediate grief and mourning needs that must be considered in a timely manner. The death of family members creates relationship losses for children that cannot be undone. Unresolved grief and mourning can result in complex psychopathology, which can impair the child's recovery from trauma. Legal and child welfare interventions often prevent the child's participation in important rituals, such as last good-byes; funerals, grave visitations, family memorial gatherings and the receiving of memorabilia from a deceased loved one. At the same time, grieving is a personally and culturally sensitive experience, so the therapist should be cautious about imposing their own views onto the child. The Standards of Care Task When child crime victims have experienced the death of a family member, the Standards of Care Task force recommends the following:

- Grief and mourning should be considered a normal process when a death has occurred.
- Children should be helped to participate directly in grief and mourning rituals in a manner appropriate to their age and developmental level.
- Professionals should collaborate to improve advocacy and support systems for grief and mourning interventions.
- Children should be assisted in obtaining photos, cherished belongings and mementos.
- Mental health treatment plans should include assessment and planning for ongoing grief and mourning needs.
- Individual and cultural differences in the manner of expressing grief should be respected.

For more information on assisting children with grief, the books *The Grieving Child* and *The Mourning Handbook,* by Helen Fitzgerald, are excellent resources.

Non-Accidental Trauma (Physical Abuse)

Non-accidental trauma (NAT) can be defined as any injury that is sustained by other than accidental means. The term non-accidental trauma is a more generic and accurate term for the entire range of circumstances that are included in the term "child physical abuse." Non-accidental trauma includes:

- Injuries that are intentional (inflicted on a child deliberately).
- Injuries that are the result of impulsive acts generated by anger and frustration.
- Injuries that are the result of harsh discipline.
- Injuries that are the result of inadequate supervision.

Effects of Non-Accidental Trauma

Children who grow up in abuse-prone environments require careful assessment and psychotherapy. When attention shifted toward child sexual abuse and away from non-accidental trauma in the 1980s, mental health referral rates for NAT declined. However, follow-up studies of non-accidental trauma children show that they are as much at risk for impaired functioning as children who were victims of child sexual abuse. For example, as a young child understands events in relation to himself, he may believe he was hurt because he was bad. Dependent upon their parents' love, children continue to strive for it even when a caseworker or therapist doubts that the parent has love to give. It is common for children suffering non-accidental trauma, even children who have been severely injured, to express a desire to be reunified with the parent(s) who were responsible for their trauma. The child's belief that parents will love and protect should not be taken as an indicator that a child will in fact be safe.

Children suffering NAT may not disclose incidents of re-abuse to a therapist for various reasons. Reasons include: trust problems created through their experience with their parents; fear of losing their connection to their parents; or anticipated reprisal and punishment. Therapists must be observant of the child's behavioral presentation and physical appearance to gain clues that abuse has recurred.

Parental context may influence the likelihood of recurrent child abuse. If substance abuse is associated with a parent's impulsive and dangerous behavior, engaging in a sobriety program is a prerequisite to their psychotherapy. Persons who are responsible for such injuries are usually reluctant to admit to it at the time the injury is discovered, or when the child is brought for medical attention. Therefore, the diagnosis of non-accidental trauma is most often established by a physician, who observes that the presenting injuries are not consistent with the given trauma history. The training and experience necessary to make such a diagnosis is becoming recognized as a pediatric specialty.

Treatment Issues Specific to Non-Accidental Trauma

The treatment of intrafamilial physical abuse is a complex process that requires a thorough assessment of the entire family system. The child's needs and the family's characteristics must be considered for treatment to be successful.

The degree of intentionality in the act(s) of non-accidental trauma must be assessed as accurately as possible. The treatment plan depends on that assessment. So may the child's health and safety. Caregivers who intentionally and deliberately inflict injuries on children may not be treatable and certainly should not be given unsupervised access to a child.

Treatment planning faces special challenges in the situation of non-accidental abuse. To plan an intervention, it is crucial to assess how intentional the physical abuse was. This has to be done to devise treatment in a way that keeps the child safe while attempts are made to remedy the situation. A child who continues to live

under threat or in actual danger will continue to adapt with protective behaviors, and therapy to relieve him of these behaviors may be harmful. However, clear knowledge of the actual circumstances in which the child was injured may be difficult or impossible to get. Accuracy, although elusive, is vital to the child's welfare. Overestimating the risk to the child can result in unnecessary periods of out-of-home placement or reduced parental contact, conditions which can in themselves cause the child significant emotional distress. Underestimating the risk to the child can result in exposing him or her to an abuse-prone environment, which can have an even more detrimental, if not fatal, outcome.

Treating the causes of non-accidental trauma poses a different problem from the treatment of child sexual abuse. One generally assumes in cases of child sexual abuse that the desire for sexual gratification is a significant component in the etiology of the trauma. One generally doesn't assume in cases of non-accidental trauma that gratification was a component, although there certainly are such cases and they pose the highest risk to a child's survival. In most cases, it is assumed that the acts that injured the child were carried out to compel a change in the child's behavior. Thus treatment strategies for cases of non-accidental trauma can be developed that both validate the caregiver's intentions and focus on changing the means of achieving them (see the section on PCIT in the "Treatment" chapter). Anger management, parent education, infant and toddler care, and effective methods of discipline (without inflicting physical pain) are common and useful components of a parent treatment program. Individual psychotherapy for the parent may also be helpful.

Treatment goals for the child must include working out how the child can protect himself after returning to the parent. This includes teaching him to ask for help from others if he feels unsafe and to understand what changes have been made to protect him from further abuse. The child's experiences during visits with the offending parent must be processed in the therapy.

Conjoint therapy between the child victim and the offender parent(s) is often a necessary stage to the child's recovery, if the child's developmental level is such that conjoint work is possible. A condition of participating in the conjoint therapy must be that the offender is willing to accept responsibility for the abuse. While it is not advisable for the same therapist to treat both the parents and the child, it is preferable to do so than to defer the treatment of either parent(s) or child if only one therapist is available. If the parent continues to be unable to explain how the injuries occurred, the prognosis for reunifying the family is poor.

Treatment goals for conditions that impair parenting abilities include the use of adjunctive and consultative services and referring the client to appropriate resources. Among the adjunctive services are drug and alcohol treatment programs. Consultative services include psychiatric assessment and medication evaluation and management. Appropriate referrals exist on a continuum from support groups to educational programs. The role of the therapist is to assist the client in accurately assessing need and developing and maintaining motivation to use resources.

When the abuse results in severe physical injuries that require medical treatment, the physical healing process must be incorporated into the treatment process. When injury has occurred, the treatment process should include assisting the child to understand the medical treatments provided and the healing process. Children should be allowed to make as many decisions as reasonably possible about medical procedures to increase their sense of control over their bodies and the events in their lives.

New caregivers such as a stepparent or another adult can increase the risk of physical abuse to children and present additional treatment concerns. Lack of bonding between the new caregiver and child, resentment of the child, conflict in discipline styles, abdication of responsibility for discipline by the biological parent and individual characteristics of the new caregiver may disrupt the equilibrium of a previously stable family system. Treatment for abuse that occurs after a new caregiver enters the family may include family therapy directed to blending families and clarification of parental roles and boundaries. Goals for treating individual characteristics that contribute to abuse have been previously discussed. The continuation of the relationship between the biological parent and the new caregiver must be evaluated in terms of the safety of the children.

Sexual Abuse

Child sexual abuse can be defined as any sexual activity with a child where consent is not or cannot be given (Finkelhor, 1979). This includes sexual contact that is accomplished by force or threat of force, regardless of the age of the participants, and all sexual contact between and adult and a child, regardless of whether there is deception or the child understands the sexual nature of the activity. Sexual contact between a teenager and a younger child is also abusive if there is a significant disparity in age, development, or size that renders the younger child incapable of giving informed consent (Ryan, 1991), or behavior between a child and an adult that would ordinarily occur between two consenting adults. Sexual abuse of one sibling by another is included in this description.

This definition includes abuse that is physical (fondling, penetration), visual, (voyeurism, viewing pornography) or verbal (sexual references, belittling the child's sexual development, instructing them how to perform sexual acts). The California Penal Code describes in detail each of the categories of criminal child sexual abuse and the conditions that determine what constitutes a misdemeanor or a felony charge. Therapists treating child victims need to be familiar with these code sections as a reference for understanding the context in which the court actions are taken.

Intrafamilial child sexual abuse — like substance abuse and domestic violence — can contribute to family dysfunction. It is not unusual for sexual abuse by a parent to take place over a period of years, eventually involving several if not all of the children in the family. All children in the family — even those identified initially as derivative victims or non-victims — could be primary victims who are reluctant to disclose. Even when a child is not a primary victim, his or her knowledge or suspicion about the sexual abuse of a sibling can have serious emotional consequences; and the sibling relationship can be deformed in significant ways. This situation has important implications for treatment and placement.

Child victims of long-term intrafamilial sexual abuse are traumatized by the incest and may be secondarily traumatized by the response of family members and helping professionals when the abuse is disclosed. The offender often initially denies or minimizes the abuse, and other family members often believe the offender and blame the victim. Thus the victim may lose the support of immediate and extended family members and feel emotionally abandoned. This dynamic is a strong contributor to victims recanting disclosures of sexual abuse because they want to comply with the family rules of secrecy and avoid being abandoned and treated as an outcast.

When assessing child sexual abuse, it is important to maintain an intergenerational perspective. Both male and female parents of abused children may have experienced victimization in childhood that has gone unacknowledged and untreated. This may significantly impact their willingness to obtain services for their children and their openness to participating in their own or their children's treatment.

Effects of Sexual Abuse

Sexual abuse of any type or duration can be traumatic and result in many kinds of harm to the child. Sexual abuse by a parent or parent figure disrupts the parent-child relationships, causes role reversal between parents and the child and generates extreme feelings of guilt and shame in the victim. Confusion in the family relationships intensifies the child's distress and makes him or her more vulnerable to being traumatized by the experience. Sexual abuse of one sibling by another alters family boundaries, creates a sense of fear and guilt in the victim and produces an imbalance in the power structure of the family.

The effects of sexual abuse vary and are influenced by several factors such as the age and developmental phase of the child at the onset of abuse, the relationship of the offender to the child and the duration of the abuse. Violence, threat or coercion occurring at any time during the abuse will also determine how the child is affected by the abuse. Finally, individual characteristics of the individual child, such as temperament, strengths, sensitivities, intelligence, will lessen or heighten the effects of the abuse.

Family strengths and weaknesses also determine how the abuse impacts the victim. This includes the presence of family dysfunction including substance abuse, domestic violence, intergenerational history of abuse and the degree of support from the non-offending parent and other family members. Molestation by a stranger is traumatic but the feelings the child has for the offender are usually not ambivalent or confused. The situation is straightforward and the child can more easily count on emotional support from those around them. They are also clear about where to focus their anger. That is often not the case in intrafamilial sexual abuse.

The quality of system intervention can also mitigate or aggravate the effects of the abuse. The sensitivity of law enforcement interventions, the number of interviews conducted, the extent to which the victim is allowed to make choices and the availability of supportive programs to prepare the victim for court are all examples of how system interventions can impact the outcome. The prompt availability of quality mental health interventions also reduces the negative effects of the trauma.

Treatment Issues Specific to Sexual Abuse

Treatment of the Child Victim

Treatment goals for the child victim include reduction of emotional symptoms including anger, fear, anxiety, depression, shame and guilt. Specific emotions that must be addressed in treatment planning include feelings of ambivalence, anger and fear towards the offender. The child may also perceive that the non-offending parent failed to protect them. Feelings that are a result of this perception of the child must also be addressed. A second goal is the reduction of behavioral symptoms, including sexual acting out, compulsive behaviors, self-destructive behaviors and aggressive behaviors. The secondary gains the child received as a result of the abuse, such as attention, gifts, and special privileges, may have influenced the child's development and contributed to behaviors which will cause future difficulties in his interpersonal relationships. The child victim may also have distorted belief systems such as self-blame, feelings of responsibility for the abuse, a sense of being stigmatized, and being unable to trust others. The child may be faced with the struggle to recant the allegations in order to restore equilibrium in the family system, resulting in overwhelming internal conflict.

The effects of sexual abuse are manifested on a spectrum of presenting mental health issues. These range from aggression to withdrawal and depression. Age inappropriate sexual acting out behaviors, promiscuity, fears and anxiety, self-destructive behaviors including self-mutilation and suicide attempts are also common outcomes of sexual abuse. Additional behavioral outcomes of sexual abuse can include overeating, anorexia, running away and substance abuse.

Treatment must address the issues listed above. The modality of treatment chosen must be appropriate for the child's stage of development and communicative skills, and must be coherently planned in relation to the target behaviors or the principle issues with which the child is struggling. Successful treatment of the child victim requires that the child be safe from further acts of abuse, either by the child's removal from the home or by the offender leaving the home.

Treatment of Siblings

One of the primary issues specific to the treatment of siblings of an abused child is a complete assessment of the sibling's own trauma history. Siblings of the victim may also have been subjected to abuse, but may not have made a disclosure as yet. The emotional responses of the sibling to the victim's disclosure of the abuse may include anger, guilt and fear. The sibling may have experienced feelings of jealousy as a result of observing the favored status of the victim. The sibling may also be overwhelmed with feelings of helplessness and powerless in the face of a perceived inability to protect the victim. Conversely, the victim may be blamed for the abuse and the subsequent separation of the family. These issues must be addressed in the therapy of the sibling in order to develop or restore a healthy, mutually respectful and protective relationship between the victim and his siblings.

Treatment of the Non-Offending Parent

The successful treatment of the non-offending parent is essential in altering the family dynamics and ensuring the ongoing safety of the child victim. Treatment issues that must be addressed in the treatment of the non-offending parent include reducing denial and minimization of the child's victimization and accepting the extent of the abuse and its impact. The non-offending parent must clearly assign responsibility for the abuse to the offender and develop empathy for the child. Additional treatment issues include addressing the non-offending parent's feelings of betrayal and violation by the offender. If the non-offending parent has a history of childhood victimization of sexual abuse that has not been treated, an opportunity to treat the childhood abuse issues is presented. Treatment of the early trauma issues clears the way for the non-offending parent to develop the capacity to protect the child from future abuse and to feel more empathy for the child. Developing the non-offending parent's capacity to protect the child must be a priority in the treatment of the non-offending parent. This requires that the non-offending parent develop understanding of the offender's cognitive distortions, grooming behaviors and any other indicators that the offender may victimize a child again.

Family Therapy Treatment Issues

Family issues that must be addressed in the therapy process include open discussion of the abuse and open acknowledgment of responsibility by the offender for the abuse. All family members must understand that the abuse occurred and how it has impacted the victim and other family members. Specific requirements for safety within the family must be established. These requirements should be designed to greatly reduce the risk of any type of maltreatment within the family. Openness about the abuse reduces the risk of perpetuating family secrets and increases the probability that a family member will ask for assistance if safety concerns arise. Issues regarding the continuation of the relationship between the offender and the non-offending parent must be addressed. This issue must be addressed as an adult to adult issue, with no responsibility for the relationship being placed on the child.

If the child is in an out-of-home placement, the involvement of the caregiver in the therapy is critical for a successful outcome. The foster parent or relative caregiver must be able to support the child through the therapy process by tolerating the child's full range of emotion and by helping the child to generalize therapy progress to other life situations. Direct or indirect messages given to the child by caregivers about the abuse and the offending parent must be carefully monitored.

Reunification Treatment Issues

When the child returns to the home where the offender lives, or the offender returns to the home where the child lives, certain tasks must have been accomplished and specific safeguards must be in place. Of primary importance is the victim's openness to living in the same home with the offender. This can be determined by the victim's reports of feeling safe in the family, perceiving that support from other family members is available and understanding that his or her safety is a primary concern for the family. The victim should also possess knowledge that the offender has made progress in treatment and has clearly stated that his behaviors were wrong and damaging to the victim and other family members. He must have admitted the abuse and taken full responsibility for it. It should be verified that the offender has completed a treatment program and be involved in an ongoing after-care program. The non-offending parent must hold the offender responsible for the abuse, believe the child, and demonstrate a capacity to support and protect all children in the family. If the offender and victim are siblings, the parents must be fully able to protect the victim and develop a pathway within the family for the victim to disclose any inappropriate behavior on the part of the sibling offender.

Siblings of the child victim likewise must be clear that the abuse is the responsibility of the offender, and they should not hold the victim responsible for the abuse or any disruption that may have occurred in the family as a result of the disclosure.

Attitudes toward Offenders

It is vital to successful treatment that therapists be aware of their own attitudes toward offenders and non-offending parents in intrafamilial cases of child sexual abuse. The therapist must accept that the child has both positive and negative feelings toward family members, including the offender. These relationships are complex, and most child victims have ambivalent feelings toward their parents. This is one of the primary differences in the dynamics of child molestation by a family member or person in position of trust (known to the child) as opposed to the child being molested by a stranger.

If the child and the accused perpetrator are still living in the same place, the primary consideration in any intervention or treatment must be protection of the victim and other children residing in the household. If there is no admission by the offender, or acknowledgment by the non-offending parent that the sexual abuse occurred, the treatment of the victim will be far more complicated. In such cases, the primary goal is protection of the victim from re-victimization. The therapist should be willing to take an active role in working cooperatively with other professionals to provide protection for the victim and to reconstruct as many of the family relationships as safely possible. This may include joint therapy sessions between the victim and other family members being treated by different therapists if such sessions would benefit the victim. It is important to be aware of how much a child victim wants to be accepted by at least some members of their family of origin. Working toward that goal can have very positive outcomes for the child even if they will never again be able to safely reside with the family.

When treating the intrafamilial sexual offender, it is important for therapists and other service providers to remember that sexual offenders are very reluctant to admit their offenses and usually only do so when confronted with the threat of serious consequences (prosecution, incarceration, loss of wife and children). Even the most compliant and remorseful offender must have serious consequences for resisting treatment or violating a "no contact" plan.

Treatment interventions proven to be most effective in reducing the risk of relapse include a variety of modalities found to be successful in treating long-term family dysfunction. Guiding principles for sound clinical interventions include:

- Providing a combination of individual, group, and family therapy, along with a guided self-help component if available.
- Developing a structured treatment plan with attention to the sequence and timing of treatment interventions and the goals to be accomplished.
- Providing access to long-term therapy and episodic returns to treatment as needed.
- Assigning multiple therapists who are able to coordinate the treatment of various family members. The therapist for the victim must be different from the therapist for the offender.
- Creating opportunities for conjoint therapy sessions among family members.
- Utilizing therapists who are experienced in the treatment of both children and offenders.
- Addressing the issue of relapse prevention prior to termination.

There are also contraindications for effective family treatment in cases of intrafamilial abuse. They are as follows:

- The offender denies that molestation occurred.
- The offender admits the molestation but blames the victim.
- The non-offending parent denies that molestation occurred and allies with the offender against the child.
- The non-offending parent believes that molestation occurred, but blames the child, fails to protect the child, and minimizes the abuse or is hostile to the child.
- The non-offending parent chooses the offender over the victim, thus abandoning the child.

Summary

Guiding principles for treating intrafamilial abuse should include the use of consultation, collaboration with adjunctive services and external systems, and coordination among treatment providers. If these guidelines are incorporated into the therapy process and the family is motivated to pursue treatment, the prognosis for a successful outcome is good.

The Standards of Care Task Force identified several general principles in the treatment of intrafamilial abuse that can be applied irrespective of specific maltreatment type. These are as follows:

- The safety of the child requires a thorough initial assessment and continuing vigilance regarding risk.
- Treatment is best carried out with multiple therapists. This requires coordination, collaboration and consultation among several treatment providers.
- All family members should have access to therapy, including child victims, siblings, non-offending parents and offenders.
- The therapist must be able to navigate through multiple systems, including law enforcement, the courts and child welfare services.
- Children and families often need advocacy as they interact with other agencies and systems.
- Family therapy is an essential component of a successful treatment plan for intrafamilial abuse, although who to include in sessions and the timing of sessions requires considerable clinical judgement.
- Group therapy is often beneficial in intrafamilial abuse cases to help reduce isolation, decrease denial, normalize traumatic events, and to encourage peer group empathy and emotional support.
- When parenting ability is impaired (for example, by substance abuse or mental illness), treatment must include the use of adjunctive and consultative services and referral of the client to appropriate resources.
- Treatment plans may require strategies for recontact between the victim and offender, such as conjoint therapy or monitored visitation.
- The therapist must be able to tolerate strong feelings within the family system and also be able to process personal feelings in order to remain objective in the therapy process.

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